DEFENDANT GGL

EXHIBIT 5

74980
1/11/05 JP

FLOWERS HOSPITAL, INC. OPERATIVE REPORT

4370 WEST MAIN STREET DOTHAN, ALABAMA 36305 (334) 794-5000 ext 1177

PATIENT NAME: WILLIAMS, EVA MEDICAL RECORD #: 262705

OPERATIVE DATE: 12/14/2004 PHYSICIAN: James Dehaven, MD

DOB: [redacted] ROOM #: 523-P
SSN: [redacted]

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PREOPERATIVE DIAGNOSIS: Degenerative joint disease, right hip.

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SURGEON: Dr. Dehaven.
ASSISTANT: Dr. Lolley.
ANESTHESIA: Spinal.
MATERIALS FORWARDED TO LABORATORY: The right femoral head.

OPERATIVE DIAGNOSIS: Degenerative joint disease, right hip.

OPERATION PERFORMED: Right total hip arthroplasty using a DePuy 56 mm. series 300 cup with apex hole eliminator and 28 mm. Marathon plastic liner. Femoral size was 13.5 small stature AML stem with a +1.5 28 mm. ceramic Articul/Eze ball.

DESCRIPTION: This patient was taken to the operating room where spinal anesthesia was obtained. She was placed in the left lateral decubitus position on a Montreal positioning device and secured with an axillary roll. The right lower extremity was prepped and draped in the usual fashion. An incision was then made over the lateral aspect of the right hip, carried down through skin and subcutaneous tissue. The iliotibial band and tensor fascia was split longitudinally for the length of the wound and Charnley bow retractor was placed. The anterior portion of the gluteus medius was then detached along with the greater trochanter and allowed to retract anteriorly and superiorly. The joint capsule was freed along the anterior, superior, and inferior femoral neck and split in a T-type fashion up to the acetabulum. The hip was then dislocated. A very valgus unusual formed femoral neck and ball; therefore, I made a real high cut because the tip of the greater trochanter was about at the inferior aspect of the acetabulum rather than the center and then I had to trim off some osteophytes in that area. I placed retractors into the acetabulum and debrided the labrum. The transverse acetabular ligament was released. The pulvinar area was then curetted. Small reamers were then used to ream back to roughened bleeding bone and then progressively reamed up to a 54 mm. diameter. Trialed 54 mm. fit very nicely. It was then removed. The cup was irrigated with a Pulsavac. A 56 mm. series 300 cup and DePuy was then hammered into the cup until fully seated. Provisional liner was then placed into the cup. The proximal femur was approached by using the box chisel to make the initial cut. T-handled reamer defined the canal and then progressively reamed to a 13-0 to accept a 13.5 prosthesis. Broached all the way to the 13.5, calcar reamer was used to smooth the calcar area and then a provisional neck and short ball was placed. The hip was then reduced and excellent range of motion, stability and leg length. It was then dislocated. The provisional components were removed and apex hole eliminator was placed into the acetabulum and then a 28 mm. Marathon liner was then placed into the cup and hammered until fully seated. The proximal femur was

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then copiously irrigated with the Pulsavac. A 13.5 small stature AML stem was then placed down the proximal femur until fully parked at the calcar. Again, provisional short ball was the best for leg length and stability. It was then dislocated and the Morse taper cleaned and a 28 mm. ceramic ball was placed on the Morse taper and tapped until fully seated. The hip was then reduced. Joint capsule was repaired using interrupted #1 Vicryl suture. The gluteus medius was then reattached using through bone interrupted #1 Vicryl and further reinforced with running #1 Vicryl. The iliotibial band and tensor fascia was then closed using interrupted running #1 Vicryl suture. The subcutaneous tissue closed with interrupted 2-0 Vicryl, and skin closed with staples. Sterile bulky dressing is applied to the wound and she was rolled back to the supine position and taken to the recovery room in stable condition.

jap
D: 12/14/2004
T: 12/15/2004

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